Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TEXAS 77504

Carrier's Austin Representative Box
01

Respondent Name
ABERDEEN INSURANCE CO

MFDR Date Received
JANUARY 15, 2007

MFDR Tracking Number
M4-07-3326-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 8, 2007: "The Carrier has not made a legal denial of reimbursement under the applicable rules and statutes…Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges upon reconsideration." "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules." "In this instance, the audited charges that remained in dispute after the last bill review by the insurance Carrier **$219,506.17-$76,8100.00(non disputed) = $142,696.17**...The prior amount paid by the Carrier were **$6,325.30**. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation reimbursement amount of **$100,696.83**, plus any and all interest applicable."

Requestor's Supplemental Position Summary Dated October 27, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment…The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons…The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons…"

Amount in Dispute: $158,304.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 16, 2007: "This medical dispute involves an inpatient hospital bill of Vista Hospital in the amount of $219,506.17 for dates of service 07/18/06 to 07/22/06. Preauthorization was given for one procedure for hardware removal and anterior and posterior fusion with. The hospital has charges for two procedures on two different days and has also submitted charges for implants and other items for which preauthorization was not obtained."

Response Submitted by: Beverly L. Vaughn, Attorney-At-Law, 5501-A Balcones Drive #104, Austin, TX 78731

Respondent's Supplemental Position Summary Dated March 6, 2007: "Preauthorization was given for one procedure for hardware removal and anterior and posterior fusion with a 5 day inpatient stay." "The provider has

not shown that the total services rendered or the services rendered that were preauthorized involved unusually extensive or costly services."

Response Submitted by: Beverly L. Vaughn, Attorney-At-Law, 5501-A Balcones Drive #104, Austin, TX 78731

Respondent's Supplemental Position Summary Dated August 31, 2011: "As argued in the carrier's initial response and the response to additional documents, the hospital failed to show that the hospitalization involved unusually extensive or unusually costly services. Therefore, the hospital has not shown that it is entitled to additional reimbursement."

Response Submitted by: Beverly L. Vaughn, Attorney-At-Law, 5501-A Balcones Drive #104, Austin, TX 78731

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
July 18, 2006 through July 22, 2006	Inpatient Hospital Services	$158,304.33	$19,753.60

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, effective May 2, 2006, sets out the definition of final action.
3. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
6. 28 Texas Administrative Code §134.600, 31 Texas Register 3566, effective May 2, 2006, requires preauthorization for inpatient hospitalizations.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 080-Review of this bill has resulted in an adjusted reimbursement of $0.00.
- W1 – Workers compensation state fee schedule adjustment.
- 855-002-Recommended allowance is in accordance with workers compensation medical fee schedule guidelines.
- Need invoices for rod, locking cap, screw, infuse BMP and ACCELL DBM.
- The audited charges do not exceed $40,000. In addition, the records do not demonstrate the provision of unusually extensive & costly services. Therefore, the stop-loss exception does not apply. If you disagree with this determination, provide a substantive explanation stating why you believe the services in this case were unusually extensive and costly, along with clinical documentation showing the patient characteristics or treatment characteristics that resulted in unusually extensive and costly services for patient in that DRG. In addition, present documentation showing the cost to the hospital of the unusually extensive services.
- 62-Payment denied reduced because exceeded preauthorization.
- W4-No additional reimbursement on reconsideration.
- 57-Payment denied/reduced because documentation does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
- 97-Unbundling.
- 40-No preauthorized-preauthorization for hardware removal and fusion with iliac bone graft only; no

preauthorization for implanted hardware, durable medical equipment or other charges under this code.

- 50-Unnecessary medical treatment for implants not preauthorized and durable medical equipment.
- No additional reimbursement on reconsideration.
- Documentation does not demonstrate the provision of unusually extensive and costly services. Therefore the stop loss provision does not apply. Reimbursement at per diem rate.
- Preauthorization was for anterior/posterior fusion L4-S1 hardware removal with iliac bone graft. Length of stay preauthorized was one surgical day with 5 day LOS. There was no preauthorization for two surgery days and no preauthorization for implantation of hardware. Services supplied exceed preauthorization; no preauthorization for implantation of hardware. Documentation does not support medical necessity or emergency for implants not preauthorized.
- Documentation does not support that invoices for implants are related to this surgery.
- Documentation does not support that durable medical equipment was preauthorized, supplied under emergency conditions, or that medical necessity exists.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Does a preauthorization issue exist?
6. Does a medical necessity issue exist?
7. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §133.240(a) and (e), 31 Texas Register 3544, effective May 2, 2006, state, in pertinent part, that " (a) An insurance carrier shall take final action after conducting bill review on a complete medical bill…" and "(e) The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division… " Furthermore, 28 Texas Administrative Code §133.2, 31 Texas Register 3544, states, in pertinent part "(4) Final action on a medical bill-- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or (B) denying a charge on the medical bill."

   The requestor in its position statement asserts that: "Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges upon reconsideration".

The division notes that the language of rule §133.2 applicable for the services in dispute differs from the requestor's statement above.

Review of the submitted documentation finds that the explanation of benefits was issued using the division prescribed form TWCC 62 and noted payment exception codes of "080, W1, 855-002, 62, 57, W4, 97, 40 and 50".

These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has met the requirements of applicable §133.240, and §133.2.

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $219,606.17. The Division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement asserts that "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

   > "The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive; and third, the median length of stay ("LOS") for workers' compensation inpatient admissions is three days whereas the length of stay for this admission exceeds the median LOS. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

   The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure

fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

> "The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore, the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of the surgery in comparison to other types of surgeries; and third, it was necessary to purchase expensive implants for use in the surgery."

The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

5. According to the explanation of benefits, the respondent reduced and denied reimbursement for the disputed services based upon "62-Payment denied reduced because exceeded preauthorization"; "40-No preauthorized-preauthorization for hardware removal and fusion with iliac bone graft only; no preauthorization for implanted hardware, durable medical equipment or other charges under this code"; and Preauthorization was for anterior/posterior fusion L4-S1 hardware removal with iliac bone graft. Length of stay preauthorized was one surgical day with 5 day LOS. There was no preauthorization for two surgery days and no preauthorization for implantation of hardware. Services supplied exceed preauthorization; no preauthorization for implantation of hardware. Documentation does not support medical necessity or emergency for implants not preauthorized".

   28 Texas Administrative Code §134.600(f) states in part "The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

   (1) specific health care listed in subsection (p) or (q) of this section;
   (2) number of specific health care treatments and the specific period of time requested to complete the treatments."

   28 Texas Administrative Code §134.600(p) states "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; and (3) spinal surgery".

   On July 12, 2006, the respondent gave preauthorization approval for "Anterior & Posterior fusion L4-S1 Hardware Removal/ 5 day LOS."

   A review of the Discharge Summary finds that the claimant underwent "Hardware removal, L4-L5, refusion, L4-5, 5-1 with bilateral decompression, L5-S1 re-instrumentation, L4 to the sacrum"; and "Anterior interbody fusion, L5-S1 with ALIF bone, BMP and allograft bone and AOI screw fixation."

   The Division finds that the inpatient length of stay was four days and the principal scheduled procedure was performed; therefore, the requestor did not exceed the preauthorized service. Therefore, a preauthorization issue does not exist.

6. According to the explanation of benefits, the respondent reduced and denied reimbursement for the implants based upon "50-Unnecessary medical treatment for implants not preauthorized and durable medical equipment".

28 Texas Administrative Code §134.600(l) states "The carrier shall not withdraw a preauthorization or concurrent review approval once issued." As stated above, the requestor obtained preauthorization for the principal scheduled procedure; therefore, the respondent's denial based upon medical necessity for the implants necessary for the procedure is not supported.

7. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" Review of the submitted documentation finds that the length of stay for this admission was three surgical days and one ICU/CCU; therefore the standard per diem amounts of $1,118.00 and $1,560.00 apply respectively. The per diem rates multiplied by the allowable days result in a total allowable amount of $4,914.00.
  - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
  - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $78,135.00.
  - The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
Screw Polyaxial	4	$1,035.00/each	$4,554.00
Infuse BMP	2	$4,600.00/each	$10,120.00
Allograft Bone Cance	1	$275.00	$302.50
ACCELL DBM	2	$875.00/each	$1,925.00
Cancellous	1	$1008.00	$1,108.80
Screw Synthes	1	No support for cost/invoice$	$0.00
Rod Straight Theken	2	$171.00/each	$376.20
Locking Cap Theken	4	$206.00/each	$906.40
DBM 100 ACCELL	1	$1620.00	$1,782.00
TOTAL	18		$21,074.90

- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $616.00 for revenue code 382-Blood-Whole Blood. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 382 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $1,700.00/unit for Epidural 0.1% 250ML. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is $25,988.90. The respondent issued payment in the amount of $6,325.30. Based upon the documentation submitted additional reimbursement in the amount of $19,753.60 is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $19,753.60 plus applicable accrued interest per 28 Texas Administrative Code §134.130 (134.803), due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	9/25/2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.